

CLARKE COLLEGE MEDICAL HISTORY FORM

**Please return to: Athletic Department, 1550 Clarke Dr., MS 1756, Dubuque, IA 52001
Fax: 563-588-6666**

NAME _____ SS# _____
 SPORT (S) _____ PHONE _____
 ADDRESS _____ CITY _____ STATE _____
 ZIP _____ GENDER _____ BIRTHDATE _____
 MS# _____ CAMPUS PHONE _____

Please answer **all** questions by circling "YES" or "NO". Explain "YES" answers in the area below.

- | | | |
|--|-----|----|
| 1. Have you had any medical problem or injury since your last physical?..... | YES | NO |
| 2. Have you even been hospitalized?..... | YES | NO |
| 3. Have you ever had surgery?..... | YES | NO |
| 4. Are you taking any medications, pills, vitamins, minerals, supplements, herbal treatments, or energy/enhancing drinks/powders/pills/shots/foods?..... | YES | NO |
| 5. Have you ever passed out during exercise?..... | YES | NO |
| 6. Have you ever had shortness of breath after exercise?..... | YES | NO |
| 7. Have you ever had chest pain during exercise?..... | YES | NO |
| 8. Have you ever been dizzy during a workout?..... | YES | NO |
| 9. Do you have high or low blood pressure?..... | YES | NO |
| 10. Do you have any skin problems (itching, rashes, acne)?..... | YES | NO |
| 11. Have you ever had a head injury?..... | YES | NO |
| 12. Have you ever been knocked out of unconscious?..... | YES | NO |
| 13. Have you ever had a seizure?..... | YES | NO |
| 14. Have you ever had a stinger, burner, or pinched nerve?..... | YES | NO |
| 15. Have you ever had heat or muscle cramps?..... | YES | NO |
| 16. Have you ever been dizzy or passed out because of the heat?..... | YES | NO |
| 17. Have you ever had trouble breathing or do you cough during or after activity? | YES | NO |
| 18. Have you ever had problems with your vision or eyes?..... | YES | NO |
| 19. Do you wear glasses, contacts, or protective eyewear?..... | YES | NO |
| 20. Have you ever sprained, strained, dislocated, fractures, broken, or had repeated swelling or other injuries of any body parts?..... | YES | NO |
- Please circle.
 Head Shoulder Thigh Neck Elbow Knee Chest Forearm
 Shin/ Calf Back Wrist Ankle Hip Hand Finger(s) Abdominal
 Other
- | | | |
|---|-------|----|
| 21. Have you ever had any other medical problems (mononucleosis, diabetes, etc.)? | YES | NO |
| 22. Do you have any allergies and/or hypersensitivities?..... | YES | NO |
| 23. Are you currently under the care of a physician?..... | YES | NO |
| 24. When was your last measles shot?..... | _____ | |
| 25. When was your last tetanus shot?..... | _____ | |
| 26. Have you had the Hepatitis B vaccination? If yes, dates?..... | _____ | |
| 27. When was your last menstrual period?..... | _____ | |
| 28. What was the longest time between periods in the past year?..... | _____ | |

Explain "YES" answers below.

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of athlete _____

Date _____

Signature of parent/guardian (if a minor) _____

Date _____